SALEM REGIONAL MEDICAL CENTER

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name :_____ Date of Birth: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

I request that my protected health information from Salem Regional Medical Center be disclosed to:
Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I authorize the following protected health information to be released from my medical record(s):
Emergency Room Record Laboratory Report(s) Radiology Report(s) Radiology imaging studies/tracing/media/CD
Pathology Report Immunization Record
Abstract/ Summary (Includes Discharge Summary, History & Physical, Operative Report(s), Consultations, and Test Results)
Test Result(s) of: _____
Itemized Billing Records
Other: _____

State and/or federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates of service where appropriate):

Alcohol, Drug, or Substance Abuse Records: □Yes □No Dates: _____
HIV Testing and Results: □Yes □No Dates: _____
Mental Health: □Yes □No Dates: _____
Psychotherapy Records: □Yes □No Dates: _____

Covering the period of healthcare from: Specific Date(s): _____ to _____ **OR**
All past, present and future encounters/visits

Purpose for requesting information: Legal Insurance Personal Continuation of Care Other *(please specify other on line below):*
_____

Disclosure Format (Paper is default if not marked.): US Mail – paper format Fax (healthcare provider only)
E-mail (secure format) E-mail (unsecure format, i.e., Gmail, Yahoo) CD/Flash drive – secure format Other *(please specify):*
_____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the **Medical Records Department at the following address: 1995 East State Street, Salem Ohio, 44460-0121**. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. **If I fail to specify an expiration date/event/condition, this authorization will expire *60 days* from the date signed.**
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by the federal Privacy Rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

Witness: _____ ***Account #*** _____ ***Medical Record #***_____